

- fatality: 1970 to 1985. *Chest* 1988; 94: 914-919
2. Sears MR, Rea HH, Beaglehole R: Asthma mortality: a review of recent experience in New Zealand. *J Allergy Clin Immunol* 1987; 80: 319-325
 3. Sears MR, Taylor DR, Print CG et al: Regular inhaled beta-agonist treatment in bronchial asthma. *Lancet* 1990; 336: 1391-1396
 4. Hargreave FE, Dolovich J, Newhouse MT: The assessment and treatment of asthma: a conference report. *J Allergy Clin Immunol* 1990; 85: 1098-1111

I am puzzled by the phenomena that Brian Goldman describes, but I believe Dr. Claire Infante-Rivard is right to study the relation between indoor pollution and the incidence of asthma in children.

I practise clinical allergy near a Canadian Armed Forces base. The military families are often housed in what are supposedly temporary buildings erected 40 to 50 years ago. These dwellings are without basements, were built over a crawl space that has a sand or dirt floor and can be drafty. They are heated by forced air furnaces and ducts, without electrostatic air filters. The families report that it is almost impossible to control the dust inside the houses. Since the base is surrounded by fields and trees, moulds and pollens may also be blowing around in their homes.

I am amazed at how many of these people have symptoms or experience worsening allergy conditions within weeks or months after being transferred from other parts of Canada to this base. Several members of a family, particularly small children, may have chronic rhinitis, recurrent otitis media and asthma. On vacation elsewhere they get better, only to become ill again shortly after returning to the base.

During the 1980s we witnessed a residential building boom in Canada, particularly in southern Ontario. It is no secret that many of these oversized houses were sloppily built, to minimum standards, with the

cheapest materials, including wall-to-wall carpets laid over compressed particle board. These homes, rapidly crumbling to dust and infested with dust mites, are heated by forced air systems.

I do not know what may be affecting the New Zealanders, but I wonder if their homes are carpeted with wool or if there are wool furnishings and bedding — wool being a particularly nasty allergen for some.

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I read with great interest the recent article by Dr. Goldman. Particularly disturbing is that, despite extensive research, there is no definite agreement on the reasons for the increases mentioned. Although many theories have been advanced — including environmental factors, overtreatment and changes in disease classification — the medical community is still unable to adequately explain the increases.

What must be addressed is the role of the primary care physician in treating asthmatic patients. Although we are probably unable to reduce the incidence of asthma there are several steps we can take to reduce the death rate.

We should (a) recognize that asthma is a potentially fatal disease and all asthmatic patients are potential victims, (b) attempt to identify patients at increased risk of potentially severe or fatal attacks,¹ (c) educate all asthmatic patients and their families about the potential severity of the disease and the need for frequent monitoring, (d) alert patients to possible precipitating factors and recommend behaviour changes to avoid potential exposure, (e) ensure that the therapy prescribed is realistic and will be complied with and (f), most importantly, never underestimate the severity of an asthmatic attack.

Although these steps are probably only a beginning they do represent several factors that are often overlooked by physicians. It remains to be seen whether the upward spiral in the rate of asthma-related deaths will soon be halted; however, we owe it to our patients to minimize the risk of death from such a treatable disease.

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Reference

1. Stunk RC: Identification of the fatality-prone subject with asthma. *J Allergy Clin Immunol* 1989; 83: 477-485

Helping patients travel by air

In their review of the medical aspects of commercial air travel (*Can Med Assoc J* 1991; 144: 287-293) Dr. Olaf Skjenna and associates acknowledge the lack of published data in this area by emphasizing reliance on "guidelines developed through practical experience."

Their survey of in-flight medical emergencies on board Air Canada planes from 1982 to 1988 led them to conclude that "nearly all the serious emergencies could have been prevented by more judicious screening and preparation." Unfortunately, they do not elaborate on this conclusion or provide the data that led them to it. It stands in substantial contrast to the findings of another survey of in-flight deaths during commercial air travel.

Cummins and collaborators¹ examined the data on 577 in-flight deaths reported to the International Air Transport Association by 42 air carriers for the 8-year period from 1977 to 1984.